

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 00602 185

1. PLACE OF DEATH: *Harford*  
 County *Harford*  
 City or town *Rural - Havre de Grace*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *Life*  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State *md.* County *Harford*  
 City or town *Rural - Havre de Grace*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

3. (a) FULL NAME *Amelia Armstrong Bond* 3. (b) Social Security Number \_\_\_\_\_

4. Sex *Female* 5. Color or race *Black* 6.(a) Single, married, widowed, or divorced *Widowed*  
 6.(b) Name of husband or wife *George W. Bond*

7. Birth date of deceased (mo., day, yr.) *Nov. 28, 1872* 6.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years *74* Months *1* Days *15* If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace *Harford Co. Md.*  
 (Town, county, and state)

10. Usual occupation *House Duties*

11. Industry or business *Lawson Harris*

12. Name *Margaret* 13. Birthplace *Md.*

14. Maiden name *Margaret* 15. Birthplace *Md.*

16. Informant *Miss Lucy A. Bond.*

Address *Havre de Grace, Md. P.D. #1*

17. *Burial* Date thereof *Jan. -15 1947*  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory *Gravel Hill*

Location *Harford Co. Md.*

18. Funeral director *R. Madison Mitchell*

Address *Havre de Grace, Md.*

19. *Jan. 14* 19 *47* *G. L. Lewis M. D.*  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Jan. 12, 1947* at *11:55* A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Jan. 12, 1947* to *Jan. 12, 1947* and that I last saw him alive on *Jan. 12, 1947*

Immediate cause of death *Cerebral hemorrhage* DURATION *1 week*

Due to *Hypertension & 22 weeks*

Due to \_\_\_\_\_

Other conditions *Hypertension & 22 weeks*

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE *Daniel P. Paloe* M. D. or other \_\_\_\_\_

Address *449 Conyers Ave* Date signed *13 Jan 1947*

RECEIVED

JAN 16 1947

BUREAU 78

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner's page is especially important. Physicians: please write the causes of death clearly and legibly.

JOHN HOPKINS UNIVERSITY

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

00603

185-0

## CERTIFICATE OF DEATH

Reg. Dist. No.

## 1. PLACE OF DEATH:

County HarfordCity or town Harford Grace  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County HarfordCity or town Harford Grace  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

Frances Olivia Bond

## 3. (b) Social Security Number

4. Sex Female 5. Color or race Black 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Wm Bond6. (c) If alive, give age 86 years7. Birth date of deceased (mo., day, yr.) January 1 - 18638. AGE: Years 84 Months 0 Days 2 It less than one day - hrs. - min.9. Birthplace Ohio  
(Town, county, and state)10. Usual occupation House Duties

11. Industry or business

12. Name Frank

13. Birthplace

14. Maiden name Frank

15. Birthplace

16. Informant James E. WilliamsAddress Harford Grace Md.17. Burial Date thereof Jan. 6 1949  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory St JamesLocation Harford Grace Md.18. Funeral director T. Madison MitchellAddress Harford Grace Md.19. Jan. 6 19 49 G. L. Lewis M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3 19 49 at 5:00 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 3 19 49and that I last saw him alive on Jan 2 19 49Immediate cause of death Cerebral SclerosisHypertensionDue to Dissecting AneurysmDue to Cerebral HemorrhageOther conditions Obesity

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE Charles J. Kelly M.D.Address Harford Grace Md. Date signed 1/6/49

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00604

Reg. Dist. No. 1810

## 1. PLACE OF DEATH:

County HARFORDCity or town Harford  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County HARFORDCity or town Harford  
(If outside city or town limits, write RURAL and give nearest town)Street No. 205 LAR  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Emily Byrd

## 3. (b) Social Security Number

4. Sex FEMALE 5. Color or race W 6. (a) Single, married, widowed, or divorced WIDOWED

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 20 18778. AGE: Years 69 Months 7 Days 1 If less than one day hrs. min.9. Birthplace BALTIMORE MD  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Jacob Freedenburg13. Birthplace BALTIMORE MD14. Maiden name Elizabeth DeBriter15. Birthplace BALTIMORE MD16. Informant Mrs. Myrtle ByrdAddress 205 LAR17. Burial Date thereof Feb. 2-47  
(Burial, cremation, or removal. Which) (month) (day) (year)Cemetery or crematory St. Luke CemeteryLocation Harford MD18. Funeral director Henry ThompsonAddress Baltimore MD19. Feb. 1 19 47 Nellie D. Liles  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/31 19 47 at 6:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 19 45 to 1/31 19 47and that I last saw him alive on 1/31 19 47Immediate cause of death Diabetic PulletisDue to Diabetic PulletisDue to Diabetic PulletisOther conditions Central Nervous System

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles J. Feltner  
M. D. or otherAddress Baltimore MD Date signed Feb. 1 1947



1-35



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

136 00605

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 125-0

## 1. PLACE OF DEATH:

County HarfordCity or town Adams de Bease  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 days

Hospital, institution, or street address where death occurred:

Harford Memorial HospitalHow long in hospital or institution? 5 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Perryman  
(If outside city or town limits, write RURAL and give nearest town)Street No. R.D. #1

(If rural, give LOCATION)

2.(a) If veteran, name war None

## 3.(a) FULL NAME

R. Grayne Cline

## 3.(b) Social Security Number

118-03-85174. Sex Male5. Color or race white6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Pauline Cline Coker8.(c) If alive, give age 26 years7. Birth date of deceased (mo., day, yr.) April 1 19108. AGE: Years 36 Months 9 Days 5 If less than one day

hrs. min.

9. Birthplace Sugar Grove Virginia  
(Town, county, and state)10. Usual occupation Mechanic

11. Industry or business

12. Name James O. Cline13. Birthplace Virginia14. Maiden name Clementine Parks15. Birthplace Virginia16. Informant Mr. James C. ClineAddress Blenheim Md. P.O. #1217. Burial Date thereof Jan. 25 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory BabbsLocation Aberdeen Md.18. Funeral director Henry Tapping SonsAddress Aberdeen Md.19. 1-23 47 P. L. Lewis M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-22 19 47 at 2 35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 17 1947 to Jan 22 1947and that I last saw him alive on Jan 22 1947Immediate cause of death Uterine HemorrhageDue to Pulmonary TuberculosisDue to toxicOther conditions hemorrhage

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles F. Foley M.D.Address Johns Hopkins Date signed 1/23/47

CERTIFICATE OF DEATH

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JAN 24 1947  
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THIS CERTIFICATE IS VALID FOR

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

180

00606

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

## 1. PLACE OF DEATH:

County Harford  
 City or town Harre de Grace - Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 yrs  
 Hospital, institution, or street address where death occurred:  
Farm - Webster - Harre de Grace Road  
 How long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MD County Harford  
 City or town Harre de Grace - Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Farm on Webster - Harre de Grace Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war —

## 3. (a) FULL NAME

PETER DOMBROSKI (DAVISON)

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

not know 1907

6. (c) If alive, give age — years

8. AGE:

40

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Virginia

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

? Davidson

13. Birthplace

not know

MOTHER

14. Maiden name

15. Birthplace

18. Informant

Mrs. Sophia Gyzinski

Address

417 N. Montford Ave - Balto.

17.

Burial

Date thereof

1-14-47

Cemetery or crematory

Holy Trinity Russian

Location

Stones River, I. G. County, Md.

18. Funeral director

John G. Drebliauckas Jr.

Address

423 S. Paca St.

19.

(Date rec'd by registrar)

19

47

G. L. Lewis M.D.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 12 1947 at 1:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19—, to — 19—  
 and that I last saw him — alive on — 19—

Immediate cause of death

Accidental Burning  
partial Carbonization

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op. —

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 1/12/47  
 Where did injury occur? near Harre de Grace Harford Md.  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home  
 Means of injury Home caught on fire Injured at work? No

23. SIGNATURE

Dr. Ramsey M.D.  
Physician Medical Examiner  
 Address Aberdeen, Md. Date signed 1/12/47

UNITED STATES DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

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JAN 14 1947

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**MARYLAND STATE DEPARTMENT OF HEALTH**

**2411 N. Charles St., Baltimore**

# CERTIFICATE OF DEATH

00607 1821

Reg. Dist. No. ....

<b>1. PLACE OF DEATH:</b> County <u>Harford</u> City or town <u>Whiteford Rural</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>4 8 yrs.</u> Hospital, institution, or street address where death occurred:  How long in hospital or institution?				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Harford</u> City or town <u>Whiteford Rural</u> (If outside city or town limits, write RURAL and give nearest town) Street No. (If rural, give LOCATION) 2(a) If veteran, name war					
<b>3. (a) FULL NAME</b> <u>Emma King Dempsey</u>				<b>3. (b) Social Security Number</b>					
<b>4. Sex</b> <u>F.</u>		<b>5. Color or race</b> <u>W.</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>Widowed</u>		<b>MEDICAL CERTIFICATION</b>			
<b>6. (b) Name of husband or wife</b> <u>Chalkley B. Dempsey</u>				<b>20. DATE OF DEATH</b> <u>January 12, 1947</u> at <u>7:30 A.</u>					
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>April 1 - 1864</u>				<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>Oct. 15, 1946</u> to <u>Jan. 12, 1947</u> and that I last saw her alive on <u>January 9, 1947</u> Immediate cause of death <u>Uremic Poisoning</u>					
<b>8. AGE:</b> Years <u>82</u> Months <u>9</u> Days <u>11</u> If less than one day Hrs. mto.								<b>CURATION</b>	
<b>9. Birthplace</b> <u>Laurens Co. Pa.</u> (Town, county, and state)				<b>Due to</b> <u>Hypertensive cardiac renal disease.</u>				<u>Unknown</u>	
<b>10. Usual occupation</b> <u>Housewife</u>				<b>Due to</b>					
<b>11. Industry or business</b>				<b>Other conditions</b>					
<b>12. Name</b> <u>Samuel King</u>				<b>(Include pregnancy within 8 months of death)</b>					
<b>13. Birthplace</b> <u>Laurens Co. Pa.</u>				<b>Major findings of operations</b> <u>None</u>					
<b>14. Maiden name</b> <u>Grace Ann Harris</u>				<b>Date of op.</b>					
<b>15. Birthplace</b> <u>Harford Co. Md.</u>				<b>Autopsy results</b> <u>None</u>					
<b>16. Informant</b> <u>Mrs. Merton Kerr</u>				<b>PHYSICIAN: Please underline the cause to which death should be charged statistically.</b>					
<b>Address</b> <u>Whiteford, Md.</u>				<b>22. VIOLENCE: If death was due to external causes, fill in the following:</b>					
<b>17. Burial</b> (Burial, cremation, or removal. Which?) Date thereof <u>Jan. 14 - 1947</u> (month) (day) (year) Cemetery or crematory <u>Gettysburg cemetery</u> Location <u>Gettysburg, Pa.</u>				<b>Accident, suicide, or homicide</b> Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work					
<b>18. Funeral director</b> <u>Wm. H. Kirk</u>				<b>23. SIGNATURE</b> <u>Charles C. Hoff MD</u> D. or other Address <u>Street, Md.</u> Date signed <u>1-12-47</u>					
<b>Address</b> <u>Gettysburg, Pa.</u>									
<b>19. (Date rec'd by registrar)</b> <u>Jan. 13, 1947</u>				<b>Registrar</b> <u>M. H. Kirk</u>					

10000

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

1. NAME OF DECEASED

DATE OF DEATH

MEDICAL CERTIFICATE

RECEIVED  
JAN 25 1947  
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2-1820-2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

121

00608850

Reg. Dist. No.

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County Harford  
 City or town Habre de Grace  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 9 days  
 Hospital, institution, or street address where death occurred:  
Harford Memorial Hospital  
 How long in hospital or institution? 9 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Cecil  
 City or town Port Deposit RD #1  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

SARAH DEVINE

## 3. (b) Social Security Number

none

## 4. Sex

female

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

widowed

## 6. (b) Name of husband or wife

Thomas Devine

## 6. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of

deceased (mo., day, yr.)

December 30, 1855

## 8. AGE:

Years

Months

Days

If less than one day

9125

hrs. min.

## 9. Birthplace

(Town, county, and state)

Maryland

## 10. Usual occupation

Housewife

## 11. Industry or business

## FATHER

## 12. Name

Wesley Oldham

## 13. Birthplace

Maryland

## MOTHER

## 14. Maiden name

Mary Taylor

## 15. Birthplace

Penna

## 16. Informant

Mrs Melvin Jackson

## Address

North East Md

## 17. (Burial, cremation, or removal. Which?)

Burial

## Date thereof

Jan 20 47

## Cemetery or crematory

Bay View Methodist

## Location

Bay View Md

## 18. Funeral director

Super R. Gorman

## Address

North East Md

## 19. (Date rec'd by registrar)

Jan. 25 1947G. L. Lewis Jr.

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

1-25-47 at 12 A. M

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 16 1947 to Jan 24 1947

## and that I last saw him alive on

Jan 16 1947

## Immediate cause of death

Perforating Infarct

## DURATION

2 hr.

## Due to

## Due to

## Other conditions

Acute Appendicitis 9 days

(Include pregnancy within 3 months of death)

## Major findings of operation

Ruptured appendix

## Peritonitis

Date of op. 1/16/47

## Autopsy results

PHYSICIAN: Please underlie the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

## 23. SIGNATURE

B. J. Benson M.D.

## Address

Port Deposit MdDate signed 1/25/47



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JAN 28 1947

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00609

Reg. Dist. No. 1820

## 1. PLACE OF DEATH:

County Harford  
 City or town Forest Hill  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Harford  
 City or town Forest Hill  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Arabelle Truaphana Durham

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Charles Howard Durham

7. Birth date of deceased (mo., day, yr.) Sept. 3, 1874 8. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 72 Months 4 Days 11 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Forest Hill Harford Co. Md  
 (Town, county, and state)

10. Usual occupation Housewife

## 11. Industry or business

12. Name William Grafton13. Birthplace Forest Hill, Md14. Maiden name Mary J Barnes15. Birthplace Perma16. Informant William G. DurhamAddress Forest Hill, Md.

17. Burial Date thereof Jan 18, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Old Branch BaptistLocation Near Jarrettsville, Md.18. Funeral director Martin G. KuryAddress Jarrettsville, Md.19. 1/16 47 Priscilla Toward

(Date rec'd by registrar) \_\_\_\_\_ Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 15 1947, at \_\_\_\_\_ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 14 1947, to Jan 15 1947

and that I last saw her alive on Jan 15 1947

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Cerebral Hemorrhage Sudden

Due to Terminating

Due to Essential Hypertension

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State) \_\_\_\_\_

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Willard P. Hudson M. D. or other \_\_\_\_\_

Address Forest Hill Md Date signed 1/16/47

RECEIVED

JAN 21 1947

BUREAU V S.

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 00610 1947

1. PLACE OF DEATH: *Harford*  
 County *Harford*  
 City or town *Rural - Grace de Grace*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *48 yrs*  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State *Maryland* County *Harford*  
 City or town *Rural - Grace de Grace*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. *Webster*  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war *none*

3. (a) FULL NAME  
*Harry John Eloner*

3. (b) Social Security Number

4. Sex *Male* 5. Color of skin *White* 6. (a) Single, married, widowed, or divorced *Single*

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) *October 23<sup>rd</sup> 1898* 6. (c) If alive, give age years

8. AGE: Years *48* Months *2* Days *11* less than one day *hrs. min.*

9. Birthplace *Harford Co. Md.*  
 (Town, county, and state)

10. Usual occupation *Farmer & Farmer*

11. Industry or business

12. Name *Harry W. Eloner*

13. Birthplace *Harford Co. Md.*

14. Maiden name *Augusta C. Goethe*

15. Birthplace *Germany*

16. Informant *Mrs. Edna M. Burnes*

Address *120 S. Washington St. Grace de Grace*

17. Burial, cremation, or removal Which? *Burial* Date thereof *Jan. 23 1947*  
 (month) (day) (year)

Cemetery or crematory *St. Luke's*

Location *St. Luke's*

18. Funeral director *Henry Taxen & Sons*

Address *St. Luke's Md.*

19. *Jan 22 1947* *Nellie H. Riley*  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *Jan 20 1947* at *5:30 P.M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Jan 20 1947* to *Jan 20 1947* and that I last saw him alive on *Jan 20 1947*

Immediate cause of death *Cerebral Thrombosis*

Due to *Cerebral Thrombosis*

Due to *Cerebral Thrombosis*

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *Charles J. Foley M.D.*

Address *St. Luke's Md.* Date signed *1/21/47*

RECEIVED

JAN 23 1947

BUREAU V.B.

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00611

Reg. Dist. No. 1820

## 1. PLACE OF DEATH:

County Harford  
 City or town Rural R.F.D. RFD  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

M ROBERT FLEMING

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

widowed

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... JANUARY 14, 1947, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

JAN. 8, 1947, to JAN. 14, 1947

and that I last saw him alive on JAN. 8, 1947

Immediate cause of death

BRONCHO - PNEUMONIA

DURATION

6 DAYS

Due to.....

Due to.....

Other conditions BENIGN PROSTATIC HYPERTROPHY 5 YEARS

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury

Injured at work?

23. SIGNATURE

Robert A. Barthel MD

M. D. or other

Address FOREST HILL MD Date signed 1/14/47

## 11. Industry or business

12. Name William Fleming

13. Birthplace

Penna

14. Maiden name

unknown

15. Birthplace

unknown

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

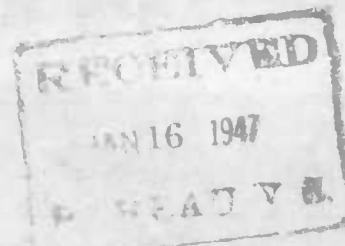
19.

(Date rec'd by registrar)

1947

Priscilla Lowwood

Registrar



1-35



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

83a

00612 1821

★ Reg. Dist. No. 184

## 1. PLACE OF DEATH:

County... Harford  
 City or town... Charlottesville Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 22 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Md County... Harford  
 City or town... Charlottesville Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No...  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war... Spanish American

## 3. (a) FULL NAME

Wm. H. Garrettsen

## 3. (b) Social Security Number

Ms

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, divorced Married

6. (b) Name of husband or wife Marion Garrettsen  
alive 6. (c) If alive, give age... years  
 7. Birth date of deceased (mo., day, yr.) March 22, 1874

8. AGE: Years 72 Months 9 Days 4 If less than one day... hrs. ... min.

9. Birthplace... Harford Co., Md.  
 (town, county, and state)

10. Usual occupation... Painter

11. Industry or business... Housework

12. Name... E. C. Garrettsen

13. Birthplace... Baltimore Md.

14. Maiden name... Lydia Grosch

15. Birthplace... Baltimore Md.

16. Informant... Mrs. Marion Garrettsen

Address... Charlottesville, Md. Rural

17. Burial, cremation, or removal... Burial Date thereof... Jan. 7, 1947  
 (month) (day) (year)

Cemetery or crematory... Charlottesville Cem.

Location... Harford Co., Md.

18. Funeral director... H. S. Bailey

Address... Charlottesville Md.

19. Date rec'd by registrar... Jan. 5, 1947 Registrar... M. V. Kivik

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH... 1-5- 1947, at 5-4 PM

I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 28 1946 to Jan 5 1947  
 and that I last saw him alive on Jan 4 1947

Immediate cause of death... Cerebral hemorrhage DURATION 6, 11 months

Due to...  
 Due to...  
 Other conditions...  
 (Include pregnancy within 8 months of death)

Major findings of operations... Date of op...

Autopsy results...  
 PHYSICIAN: Please underlie the cause to which death should be charged statistically.

VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... Date of...

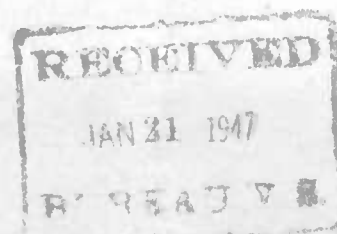
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. E. Gallion M. D. or other

Address... Charlottesville Md. Date signed 1-5-47



2-25

2-1820 — 2-10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

00613 P

1952

<b>1. PLACE OF DEATH:</b> County... <u>Harford</u> City or town... <u>Home de Grace</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>2 hours</u> Hospital, institution, or street address where death occurred: <u>Harford Memorial Hospital</u> How long in hospital or institution? <u>2 hours</u>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State... <u>2nd</u> County... <u>Baltimore</u> City or town... <u>Fulleton</u> (If outside city or town limits, write RURAL and give nearest town) Street No. _____ (If rural, give LOCATION) 2.(a) If veteran, name war _____			
<b>3. (a) FULL NAME</b> <u>CHARLES JOSEPH GERST</u>				<b>3. (b) Social Security Number</b>			
<b>4. Sex</b> <u>Male</u>		<b>5. Color or race</b> <u>White</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>Married</u>			
<b>B. (b) Name of husband or wife</b> <u>Cecilia B. Gerst</u>				<b>6. (c) If alive, give age</b> _____ years			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>June 9<sup>th</sup> 1893</u>				<b>8. AGE:</b> Years <u>53</u> Months <u>7</u> Days <u>1</u> It less than one day _____ hrs. _____ min.			
<b>9. Birthplace</b> <u>Balto. Co., Md.</u> (Town, county, and state)				<b>10. Usual occupation</b> <u>Shell - Organ and</u>			
<b>11. Industry or business</b> <u>Farmer</u>				<b>12. Name</b> <u>Peter Gerst</u>			
<b>13. Birthplace</b> <u>Balto. Co., Md.</u>				<b>14. Maiden name</b> <u>Mary Butt</u>			
<b>15. Birthplace</b> <u>Balto. Co., Md.</u>				<b>16. Informant</b> <u>Mrs. C. J. Gerst</u> Address <u>2nd Lane, Fulleton P.O. Md.</u>			
<b>17. Burial</b> (Burial, cremation, or removal) Which? <u>Burial</u> Date thereof <u>Jan. 14, 1947</u> (month) (day) (year) Cemetery or crematory <u>St. Joseph's</u> Location <u>Fulleton, Md.</u>				<b>18. Funeral director</b> <u>Rossahm Funeral Home</u> Address <u>7401 Belair Rd. Balto. 6, Md.</u>			
<b>19. 1-11</b> (Date rec'd by registrar)				<b>19. 47</b> Registrar <u>Dr. J. H. [Signature]</u>			

MEDICAL CERTIFICATION	
<b>20. DATE OF DEATH</b> <u>Jan. 10</u> 19 <u>47</u> at <u>4:30</u> M	<b>21. I CERTIFY</b> that death occurred on the date above stated; that I attended deceased from _____ 19____ to _____ 19____ and that I last saw h. _____ alive on _____ 19____ Immediate cause of death <u>Intracranial hemorrhage</u> <u>Fracture of skull</u> Due to _____ Due to _____ Other conditions _____ (Include pregnancy within 3 months of death) Major findings of operations <u>None</u> Date of op. _____ Autopsy results <u>None</u> PHYSICIAN: Please underline the cause to which death should be charged statistically.
<b>22. VIOLENCE:</b> If death was due to external causes, fill in the following: Accident, suicide, or homicide <u>Accident</u> Date of <u>Jan 10, 1947</u> Where did injury occur? <u>near Kingsville Bost. Md.</u> (City or town) (County) (State) Injured at home, farm, industry, public place (where?) <u>Construction site</u> Means of injury <u>Bucket fell on head</u> Injured at work? <u>Yes</u>	<b>23. SIGNATURE</b> <u>J. H. [Signature]</u> 24. D. <u>Deputy Medical Examiner</u> Address <u>Aberdeen, Md.</u> Date signed <u>1/10/47</u>

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95c

00615

## CERTIFICATE OF DEATH

Reg. Dist. No. 1820

## 1. PLACE OF DEATH:

County HarfordCity or town Baldwin  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? 1

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County BaltimoreCity or town Baldwin  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Margaret Haulon

## 3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

James Haulon

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9078hrs.min.

9. Birthplace

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

47

Priscilla Lowwood

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 4 1947, at 7:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1 Oct 1946 to Jan 4 1947and that I last saw him alive on Jan 4 1947Immediate cause of death Chronic Cardiac Compensation

DURATION

72Due to Grippe & BronchitisDue to 5 dy

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? 15

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Baldwin Date signed 1/6/47

RECEIVED

JAN 9 1947

BUREAU VS

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00614

Reg. Dist. No. 1830

<b>1. PLACE OF DEATH:</b> County <u>Hanford</u> City or town <u>Pylesville P.D.</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>38 years</u> Hospital, institution, or street address where death occurred: _____ How long in hospital or institution? _____				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>Md</u> County <u>Hanford</u> City or town <u>Pylesville</u> (If outside city or town limits, write RURAL and give nearest town) Street No. _____ (If rural, give LOCATION) 2.(a) If veteran, name war _____			
<b>3. (a) FULL NAME</b> <u>Sara McEntire Harry</u>				<b>3. (b) Social Security Number</b> _____			
<b>4. Sex</b> <u>Female</u>		<b>5. Color or race</b> <u>white</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>married</u>			
<b>6. (b) Name of husband or wife</b> <u>David G. Harry</u>				<b>6. (c) If alive, give age</b> <u>66</u> years			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>March 13 1880</u>							
<b>8. AGE:</b> Years <u>66</u>		Months <u>10</u>		Days <u>11</u>		If less than one day _____ hrs. _____ min.	
<b>9. Birthplace</b> <u>New Park Penna</u> (Town, county, and state)							
<b>10. Usual occupation</b> <u>Housewife</u>							
<b>11. Industry or business</b> _____							
<b>MOTHER</b>							
<b>12. Name</b> <u>Josephine Lanius</u>							
<b>13. Birthplace</b> <u>York Co Pa</u>							
<b>14. Maiden name</b> <u>Rebecca Stevens</u>							
<b>15. Birthplace</b> <u>Baltimore Md.</u>							
<b>16. Informant</b> <u>David G. Harry</u> Address <u>Pylesville Md.</u>							
<b>17. Burial</b> <u>Buried</u> Date thereof <u>Jan 27-47</u> (Burial, cremation, or removal. Which?) (month) (day) (year) Cemetery or crematory <u>Fawn Grove</u> Location <u>Fawn Grove Pa.</u>							
<b>18. Funeral director</b> <u>Martins Exhorts</u> Address <u>Lanetsville Md.</u>							
<b>19.</b> <u>Jan 27</u> 19 <u>47</u> <u>Thomas R. Brown</u> (Date rec'd by registrar) Registrar							
<b>MEDICAL CERTIFICATION</b>							
<b>20. DATE OF DEATH</b> <u>January 24</u> 19 <u>47</u> , at <u>11:56 PM</u>							
<b>21. I CERTIFY</b> that death occurred on the date above stated; that I attended deceased from <u>1938</u> to <u>Jan 24 1947</u> and that I last saw her alive on <u>January 14 1947</u>							
Immediate cause of death <u>Congestive heart failure</u>							
Due to <u>Hypertensive - C-V disease</u>							
<u>and myocarditis</u>							
Due to _____							
Other conditions _____							
(Include pregnancy within 3 months of death)							
<b>Major findings of operations</b> _____							
Date of op. _____							
<b>Autopsy results</b> _____							
<b>PHYSICIAN:</b> Please underline the cause to which death should be charged statistically.							
<b>22. VIOLENCE:</b> If death was due to external causes, fill in the following:							
Accident, suicide, or homicide _____ Date of _____							
Where did injury occur? _____ (City or town) _____ (County) _____ (State)							
Injured at home, farm, industry, public place (where?) _____							
Means of injury _____ Injured at work? _____							
<b>23. SIGNATURE</b> <u>Joseph A. Hunt M.D.</u> Address <u>Delta Penna</u> Date signed <u>1/25/47</u>							



RECEIVED

JAN 30 1947

BUREAU V C

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (130)

00616

## CERTIFICATE OF DEATH

Reg. Diat. No. 185

## 1. PLACE OF DEATH:

County HarpurCity or town Harper de Grace Md  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 12 day

Hospital, institution, or street address where death occurred:

Harper Memorial HospHow long in hospital or institution? 10 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarpurCity or town Harper de Grace Md  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Ellen Smith Juricks

## 3. (b) Social Security Number

4. Sex

F

5. Color or race

C

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife \_\_\_\_\_

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) December 1905

8. AGE:

Years

Months

Days

If less than one day

40

.....hrs. ....min.

9. Birthplace Baltimore, Maryland  
(Town, county, and state)10. Usual occupation Landress

11. Industry or business \_\_\_\_\_

12. Name Joseph McKinney13. Birthplace British Isles14. Maiden name Franca Blanton15. Birthplace Harper de Grace Md16. Informant Mrs Sarah M. MobergAddress 930 Madison Ave Balt. Md17. Burial Date thereof 2-1-47  
(Burial, cremation, or removal) (month) (day) (year)Cemetery or crematory St JamesLocation Harper de Grace Md18. Funeral director Ellen E. BullockAddress 536 Lewis St. Harper de Grace19. Feb-1 19 47 G. L. Lewis m. d.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/28 19 47 at 1:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1/28 19 47 to 1/28 19 47and that I last saw her alive on 1/28 19 47

Immediate cause of death \_\_\_\_\_

DURATION

Acute Hemorrhagic Nephritis 8 days

Due to \_\_\_\_\_

A childbirth was not involved.

Due to \_\_\_\_\_

Cause

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Acute Hemorrhagic Nephritis Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

Signature Dudley Phillips MD M. D. or otherAddress Harper de Grace Md Date signed 1/30/47

CERTIFICATE OF DEATH



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00617

Reg. Dist. No. 1800

<b>1. PLACE OF DEATH:</b> County..... <u>HARFORD</u> City or town..... <u>ABINGTON - RURAL</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: How long in hospital or institution?				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State..... <u>MD</u> County..... <u>HARFORD</u> City or town..... <u>ABINGTON - RURAL</u> (If outside city or town limits, write RURAL and give nearest town) Street No..... <u>DALTON FARM</u> (If rural, give LOCATION) 2.(a) If veteran, name war.....			
<b>3.(a) FULL NAME</b> <u>William L. Kelly</u>				<b>3.(b) Social Security Number</b> <u>212-18-2156</u>			
<b>4. Sex</b> <u>Male</u>		<b>5. Color or race</b> <u>White</u>		<b>6.(a) Single, married, widowed, or divorced</b> <u>Widowed</u>			
<b>6.(b) Name of husband or wife</b> <u>Florence Kelly</u>				<b>6.(c) If alive, give age</b> ..... years			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>June - 1881</u>				<b>8. AGE:</b> Years <u>65</u> Months <u>-</u> Days <u>-</u> if less than one day..... hrs. .... min.			
<b>9. Birthplace</b> <u>Harford, Maryland</u> (Town, county, and state)				<b>10. Usual occupation</b> <u>Laborer</u>			
<b>11. Industry or business</b>				<b>12. Name</b> <u>Lewis S. Kelly</u>			
<b>13. Birthplace</b> <u>Maryland</u>				<b>14. Maiden name</b> <u>Elizabeth Ellett</u>			
<b>15. Birthplace</b> <u>Maryland</u>				<b>16. Informant</b> <u>Russell L. Kelly</u> Address <u>Aberdeen apt 671 Md</u>			
<b>17. Burial</b> (Burial, cremation, or removal. Which?) <u>Burial</u> Date thereof <u>Jan 28, 1947</u> (month) (day) (year) Cemetery or crematory <u>Berkshire</u> Location <u>Abingdon Md</u>				<b>18. Funeral director</b> <u>Howard R. McGowan</u> Address <u>Abingdon Md</u>			
<b>19.</b> <u>Jun 28</u> <u>1947</u> <u>Mon, Monksdale</u> (Date rec'd by registrar) Registrar				<b>MEDICAL CERTIFICATION</b> <b>20. DATE OF DEATH</b> <u>Jan 23</u> 19 <u>47</u> at <u>4 P.</u> M <b>21. I CERTIFY</b> that death occurred on the date above stated; that I attended deceased from.....19....., to.....19..... and that I last saw h..... alive on.....19..... Immediate cause of death..... <u>CORONARY THROMBOSIS</u> Due to..... Due to..... Other conditions..... (Include pregnancy within 3 months of death) Major findings of operations..... Date of op..... Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically. <b>22. VIOLENCE:</b> If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?..... <b>23. SIGNATURE</b> ..... Address..... Date signed.....			

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

93d

0061882

Reg. Dist. No.

1884

### 1. PLACE OF DEATH:

County Harford

City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Harford

City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

Street No. MS  
(If rural, give LOCATION)

2.(a) If veteran, name war.

### 3. (a) FULL NAME

Geo. A. Knight

### 3. (b) Social Security Number

MS

#### 4. Sex

Male

#### 5. Color or race

White

#### 6. (a) Single, married, widowed, or divorced

Widower

### 6. (b) Name of husband or wife

Dead

### 6. (c) If alive, give age

#### 7. Birth date of

deceased (mo., day, yr.)

#### 8. AGE:

81 Years 9 Months 11 Days If less than one day

#### 9. Birthplace

Harford Co., MD  
(Town, county, and state)

#### 10. Usual occupation

Retired

#### 11. Industry or business

Farmer

#### 12. Name

W. A. Knight

#### 13. Birthplace

Harford Co., MD

#### 14. Maiden name

Jane Edcott

#### 15. Birthplace

Harford Co., MD

#### 16. Informant

Mr. Norman Knight

#### Address

Baltimore, Md.

#### 17. Burial

(Burial, cremation, or removal) Which?

#### Date thereof

Jan 23 1947  
(month) (day) (year)

#### Cemetery or place of interment

Rock Run Cem

#### Location

Harford Co., MD

#### 18. Funeral director

H. S. Bailey

#### Address

Baltimore, Md.

Jan 22 1947  
(Date rec'd by registrar)

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 1947 at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 20 1944, to Jan 21 1947

and that I last saw him alive on Jan 20 1947

Immediate cause of death

Chronic Myocarditis

Hypertension

Due to MS

Due to MS

Other conditions MS

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE J. P. H. H. H.

M. D. or other

Address Baltimore, Md.

Date signed 1/22/47

MARGIN RESERVED FOR BINDING

9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THE CORPORATION LIMITED

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 185

01049

## 1. PLACE OF DEATH:

County Harford  
 City or town Harford  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford  
 City or town Harford  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 400 N. Union  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

ETHEL MAY LEYDECKER

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married

6. (b) Name of husband or wife Philip L. Leydecker

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21 - 1898

8. AGE: Years 48 Months 8 Days 27 If less than one day hrs. min.

9. Birthplace Toronto Canada  
 (Town, county, and state)

10. Usual occupation House wife

## 11. Industry or business

12. Name Robert Brines13. Birthplace Canada14. Maiden name Erith Rose15. Birthplace Canada16. Informant Philip L. LeydeckerAddress 400 N. Union, Harford

17. Burial Date thereof 4/20/47  
 (Burial, cremation, or removal) Which? (month) (day) (year)

Cemetery or crematory Landon ParkLocation Baltimore, Md.18. Funeral director Cunningham & SonAddress Harford, Md.

19. Jan. 19 19 47 A. L. Lewis M.D.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17, 1947 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death

Intracranial Hemorrhage

DURATION

Due to Guns hot wound of Head

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of Jan 17, 1947

Where did injury occur? Harford  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) HomeMeans of injury Guns hot wound .38 cal. Injured at work? No

23. SIGNATURE

J. L. Ramsey M.D.  
Deputy Medical Examiner  
 Address Harford Date signed 1/17/47

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

## CERTIFICATE OF DEATH

Reg. Dist. No. 00837

## 1. PLACE OF DEATH:

County Harford  
 City or town Harne De Grace Md  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, institution, or street address where death occurred:

461 Revolution Street  
 How long in hospital or institution?                     

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Delaware County Queen Anne's

City or town 402 Yellow Bl  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Wilmington Del  
 (If rural, give LOCATION)

2(a) If veteran, name war                      ✓

## 3. (a) FULL NAME

Mary Ann Macklem

## 3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife                     

7. Birth date of deceased (mo., day, yr.) May 10, 1890 6. (c) If alive, give age                      years

8. AGE: Years 56 Months 8 Days 5 It less than one day                      hrs.                      min.

8. Birthplace Wilmington New Castle Del  
 (Town, county, and state)

10. Usual occupation Registered Nurse11. Industry or business State Board Health12. Name Jane A. Macklem13. Birthplace Wilmington Del14. Maiden name Jennie B. Kelly15. Birthplace Wilmington Del16. Informant Mrs Margaret J BroadwellAddress 461 Revolution Street17. (Burial, cremation, or removal. Which?) Burial Date thereof Jan 18, 1947  
(month) (day) (year)Cemetery or crematory CemeteryLocation Mt Salem18. Funeral director Albert J. J. J. J.Address Wilmington Del19. Jan 16 19 47 G. L. Lewis M.D.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH Jan 15, 1947 at 9:00 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 10, 1946 to Jan 10, 1947and that I last saw him alive on Jan 12, 1947Immediate cause of death Carcinoma of BreastDue to Carcinoma of LungDue to CarcinomaOther conditions Cystitis

(Include pregnancy within 8 months of death)

Major findings of operations                      Date of op.                     Autopsy results                     

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide                      Date of                     Where did injury occur?                      (City or town)                      (County)                      (State)Injured at home, farm, industry, public place (where?)                     Means of injury                      Injured at work?                     23. SIGNATURE Charles J. Foley M.D.Address Harne De Grace Del Date signed 1/17/47

UNITED STATES DEPARTMENT OF JUSTICE

DEPARTMENT OF JUSTICE

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Jan 18 1947  
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00620

Reg. Dist. No. 1810

## 1. PLACE OF DEATH:

County.....

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex..... 5. Color or race..... 6.(a) Single, married, widowed, or divorced.....

Female White Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... 6.(c) If alive, give age..... years

8. AGE: Years..... Months..... Days..... If less than one day..... hrs. .... min.

9. Birthplace.....  
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial..... Date thereof.....  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Jan. 23..... 1947.....  
(Date rec'd by registrar)Nellie S. Giley  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 1947 at 12:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Never. I arrived just after death p.p.k.

and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

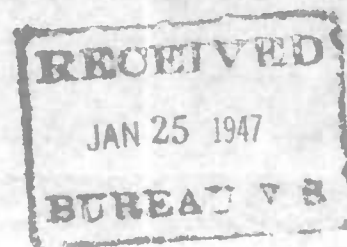
Means of injury..... Injured at work?.....

23. SIGNATURE.....

Address.....

Date signed.....





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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00621/821

Reg. Dist. No. 189

## 1. PLACE OF DEATH:

County HarfordCity or town Whitefish  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 35 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Whitefish  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Anna Taylor Norris

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

8. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of

deceased (mo., day, yr.)

Mar. 5, 1864

8. AGE:

Years

Months

Days

If less than one day

82101

.....hrs. ....min.

9. Birthplace

Harford Co. Md.  
(Town, county, and state)

10. Usual occupation

Foreman State Rd. Cons.

11. Industry or business

FATHER

12. Name

Joseph Norris

13. Birthplace

Harford Co. Md.

MOTHER

14. Maiden name

Bessie Jones

15. Birthplace

Harford Co. Md.

16. Informant

Elmer L. Houser

Address

Delta, Pa.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Jan. 8, 1947  
(month) (day) (year)

Cemetery or crematory

State Ridge Cemetery

Location

Delta, Pa.

18. Funeral director

Hubert P. Haskins

Address

Delta, Pa.Jan. 7, 1947

19. (Date rec'd by registrar)

M. V. Kirk

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 6, 1947 at 5:40 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 43 to September 1946and that I last saw him alive on September 1946

Immediate cause of death

DURATION

Coronary thrombosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Bryan D. F. Kirk

M. D. or other

Address

Delta, Pa.Date signed 1-7-47

CERTIFICATE OF DEATH

STATE OF NEW YORK

DEPARTMENT OF HEALTH

IN THE CITY OF NEW YORK

On the 21st day of January, 1947, at the City of New York, in the County of New York, I, the undersigned, a duly qualified and licensed physician, do hereby certify that the above-named person died at the residence of the deceased, at the age of 21 years, of the following disease or diseases, to-wit:   
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 1821

## 1. PLACE OF DEATH:

County HarfordCity or town Cardiff  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 yrs.

Hospital, institution, or street address where death occurred:

How long to hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Cardiff  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

William R. Orr

## 3. (b) Social Security Number

4. Sex male5. Color or race white6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Olive Orr7. Birth date of deceased (mo., day, yr.) April 1 - 18798. (c) If alive, give age 67 years8. AGE: 67 Years 9 Months 15 Days hrs. min.  
If less than one day9. Birthplace York Co. Pa.  
(Town, county, and state)10. Usual occupation Seaman

11. Industry or business

12. Name Robert Orr13. Birthplace York Co. Pa.14. Maiden name Margaret Elgers15. Birthplace York Co. Pa.16. Informant Mrs. Olive OrrAddress Cardiff, Md.17. Burial Date thereof Jan. 19 - 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory State Ridge cemeteryLocation Delta, Pa.18. Funeral director Robert P. MackinnAddress Delta, Pa.19. Jan. 18 1947 M. G. Kirk  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 16 19 47 at 11.30 P21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3 19 43, to January 16 19 47and that I last saw him alive on January 16 19 47Immediate cause of death coronary thrombosis

DURATION

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions emphysema pulmonum

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work \_\_\_\_\_

23. SIGNATURE Seon song - New

M. D. or other

Address CARDIFF Md Date signed 1-17-47

CERTIFICATE OF DEATH

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Place of death

6. Cause of death

7. Signature of physician

8. Signature of registrar

9. Signature of informant

10. Signature of witness

11. Signature of funeral director

12. Signature of undertaker

13. Signature of coroner

14. Signature of justice of the peace

15. Signature of sheriff

16. Signature of constable

17. Signature of clerk

18. Signature of treasurer

19. Signature of assessor

20. Signature of collector

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

00623

## CERTIFICATE OF DEATH

Reg. Dist. No. 1850

## 1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematorium

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19

47

G. L. Lewis M.D.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

19. 47 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed



CERTIFICATE OF DEATH

TO BE FILLED BY THE PHYSICIAN

DEPARTMENT OF HEALTH

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JAN 11 1947  
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age is

STANDARDIZATION UNIT

G 108 1/31/47

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

00624

## CERTIFICATE OF DEATH

★ Reg. Dist. No. 185-

## 1. PLACE OF DEATH:

County Harford  
 City or town Harford  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 mo  
 Hospital, institution, or street address where death occurred:  
Harford Memorial Hosp  
 How long in hospital or institution? 1 mo

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State md County Harford  
 City or town Aberdeen  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Route #2  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war none

## 3. (a) FULL NAME

Martha B. Plowman

## 3. (b) Social Security Number

none

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced S

## 6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Jan. 23, 1865  
 8. (c) If alive, give age 81 years

8. AGE: Years 81 Months 8 Days 7 If less than one day hrs. min.

9. Birthplace Harford Co., Md.  
 (Town, county, and state)

10. Usual occupation House worker

11. Industry or business Joseph Plowman

12. Name Joseph Plowman

13. Birthplace Harford Co., Md.

14. Maiden name Martha Plowman

15. Birthplace Harford Co., Md.

16. Informant Mr. Charles M. Plowman

Address 6409 Fried Ave. Balto.-7-Md

17. Burial, cremation, or removal. Which? Burial Date thereof Jan 23, 1947  
 (month), (day), (year)

Cemetery or crematory Mountain Christian

Location Belina Md

18. Funeral director Henry Tarrington & Sons

Address Aberdeen Md.

19. Date rec'd by registrar Jan. 31, 1947 Registrar A. L. Lewis M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1/20 19 47, at 3:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/20 19 47, to 1/20 19 47, and that I last saw him or alive on 1/20 19 47

Immediate cause of death Arterio Sclerosis Cardio Vascular

Due to dissecting

2 Cerebral Hemorrhage

Due to 1 mo.

Other conditions none

(Include pregnancy within 8 months of death)

Major findings of operations none

Date of op. none

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide none Date of none

Where did injury occur? none (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) none

Means of injury none Injured at work? none

23. SIGNATURE Dudley Phillipson D

M. D. or other none

Address Harford Mem Hosp Date signed 1/20/47

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

THIS CORPORATION LIMITED

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

 1248 00625  
 Reg. Diat. No. 185-

## 1. PLACE OF DEATH:

County Harford  
 City or town Harre de Grace - Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 days  
 Hospital, institution, or street address where death occurred:  
Harford Memorial, Harre de Grace  
 How long in hospital or institution? 6 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Harford  
 City or town Harre de Grace - Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war None

## 3. (a) FULL NAME

Charles E. Pierson

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) July 20, 1898

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

68

5

hrs. \_\_\_\_\_ min.

9. Birthplace

Floyd Co., Va.  
 (Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER  
MOTHER

12. Name

David Pierson

13. Birthplace

Floyd Co., Va.

14. Maiden name

Mary Gleason

15. Birthplace

Floyd Co., Va.

16. Informant

Mr. Nelson Kithley

Address

203 Wilson St. Harre de Grace

17.

(Burial, cremation, or removal. Which?) Burial

Date thereof Jan. 11, 1947  
 (month) (day) (year)

Cemetery or crematory

Bakers

Location

Aberdeen, Md.

18. Funeral director

Henry Tarring & Sons

Address

Aberdeen, Md.

19.

(Date rec'd by registrar)

19. 47

G. L. Lewis M.D.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

January 9, 1947 at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 4, 1947 to Jan 9, 1947

and that I last saw him alive on Jan 8, 1947

Immediate cause of death

Cardiac insufficiency

Secondary to

hypertension

with

bronchial asthma

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_

Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE

W. L. Lewis M.D.

M. D. or other

Address

Harre de Grace, Md.

Date signed 1-10-47

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

00626

## CERTIFICATE OF DEATH



Reg. Dist. No. 1820

### 1. PLACE OF DEATH:

County Hartford  
City or town Bel Air, Md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 60 years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Hartford  
City or town Bel Air Md  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 136 W Broadway  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

Clara C Robinson

### 3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced W

6. (b) Name of husband or wife Thomas H Robinson  
6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 19 - 1857

8. AGE: Years 89 Months Days If less than one day hrs. min.

9. Birthplace Forest Hill, Md  
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name James M Cain  
13. Birthplace Md

MOTHER 14. Maiden name Elizabeth Nean  
15. Birthplace Md

16. Informant Mrs Lucille R. Close  
Address Bel Air, Md

17. Burial Date thereof Jan 29/47  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory St Ignatius  
Location Hickory, Hartford Co.

18. Funeral director Dean & Foster  
Address Bel Air Md

19. 1/28 47 Ornella Fourvork  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 27 19 47 at 2:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 25 to Jan 26 and that I last saw her alive on Jan 26

Immediate cause of death Cerebral Hemorrhage

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide. Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE M. D. or other  
Address Bel Air Md Date signed 1/28/47

MARGIN RESERVED FOR BINDING

9-43-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

JAN 30 1947

BUREAU

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

195d

00627

## CERTIFICATE OF DEATH



Reg. Dist. No. 1830

## 1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

5. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

January 23

19

47, at 7A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19

to

19

and that I last saw him alive on

19

Immediate cause of death

DURATION

~~Obstruction of Trachea~~  
 A noxemia due to  
 Obstruction of Trachea

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

1/23/47

Where did injury occur?

Fallston  
(City or town)Harford  
(County)Md  
(State)

Injured at home, farm, industry, public place (where?)

Home

Means of injury

Inspired pneumonia

Injured at work?

no

23. SIGNATURE

Dr. C. Palmer M.D.  
 Acting Deputy Medical Examiner  
 Harford County M.D. or other

Address

Bel Air, Md.

Date signed 1/23/47

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JAN 28 1947

BUREAU V S

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00628 P  
180

Reg. Diat. No. ....

## 1. PLACE OF DEATH:

County HarfordCity or town Joppa  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Joppa  
(If outside city or town limits, write RURAL and give nearest town)Street No. New Philadelphia Road.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Paul Seneta

## 3. (b) Social Security Number

212-22-0854

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

not know 1885

8. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

61?

hrs. min.

9. Birthplace

Russian  
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

MOTHER FATHER

12. Name

? Seneta

13. Birthplace

Russian

14. Maiden name

not know

15. Birthplace

Russian

16. Informant

Mr. Bordner

Address

New Phila. Road. Joppa, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Jan - 8 - 47  
(month) (day) (year)

Cemetery or crematory

Holy Trinity Russian

Location

Stoney Run, Md. G.G. Co.

18. Funeral director

John A. Shrethiauckas, Jr.

Address

423 S. Paca St.

19.

(Date rec'd by registrar)

19.

47

F.W. Hedrick  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

January 4 1946 at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 21, 1946, to Jan 2, 1947

and that I last saw him alive on

January 2, 1947

Immediate cause of death

Coronary atherosclerosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

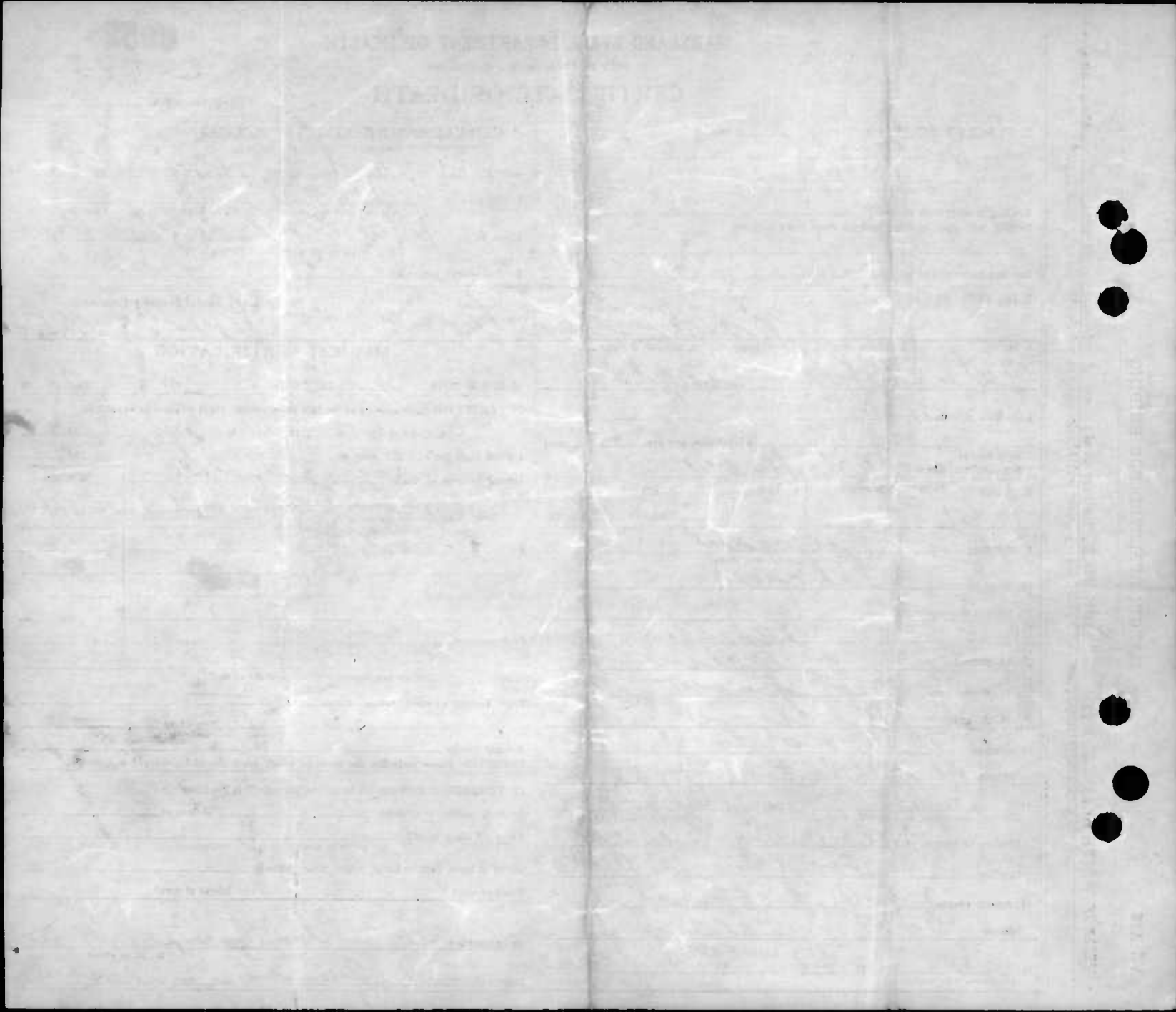
Injured at work?

23. SIGNATURE

Samuel Sibrustein M.D.  
M. D. or other

Address

22 S. Broadway Date signed Jan 6 - 1947



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 00629 1810

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

## MEDICAL CERTIFICATION

8. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematorium

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

20. DATE OF DEATH

19 47 nt 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed



RECEIVED

JAN 23 1947

BUREAU V 8

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

0063480

<b>1. PLACE OF DEATH</b> County <u>Harford</u> City or town <u>Joppa R.D.</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>Lifetime</u> Hospital, institution, or street address where death occurred: _____ How long in hospital or institution? _____				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Harford</u> City or town <u>Joppa R.D.</u> (If outside city or town limits, write RURAL and give nearest town) Street No. _____ (If rural, give LOCATION) 2.(c) If veteran, name war _____			
<b>3. (a) FULL NAME</b> <u>Ella May Spicer</u>				<b>3. (b) Social Security Number</b>			
<b>4. Sex</b> <u>Female</u>		<b>5. Color or race</b> <u>white</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>married</u>			
<b>6. (b) Name of husband or wife</b> <u>J. Elmer Spicer</u>				<b>6. (c) If alive, give age</b> <u>57</u> years			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>May 28 1887</u>				<b>8. AGE:</b> Years <u>59</u> Months <u>7</u> Days <u>11</u> If less than one day _____ hrs. _____ min.			
<b>9. Birthplace</b> <u>Maryland</u> (Town, county, and state)				<b>10. Usual occupation</b> <u>Housewife</u>			
<b>11. Industry or business</b>				<b>12. Name</b> <u>John Ray</u>			
<b>13. Birthplace</b> <u>Maryland</u>				<b>14. Maiden name</b> <u>Virginia Johnson</u>			
<b>15. Birthplace</b> <u>Maryland</u>				<b>16. Informant</b> <u>J. Elmer Spicer</u> Address <u>Joppa R.D. Maryland</u>			
<b>17. (Burial, cremation, or removal. Which?)</b> <u>Burial</u> Date thereof <u>Jan 21 1947</u> (month) (day) (year) Cemetery or crematory <u>Mountain Christian</u> Location <u>Joppa R.D. Maryland</u> <b>18. Funeral director</b> <u>Howard K. McCormack</u> Address <u>Abingdon Maryland</u>				<b>20. DATE OF DEATH</b> <u>Jan 19</u> 19 <u>47</u> , at <u>7:45</u> M <b>21. I CERTIFY</b> that death occurred on the date above stated; that I attended deceased from <u>Jan 15</u> 19 <u>44</u> , to <u>Jan 19</u> 19 <u>47</u> and that I last saw her alive on <u>Jan 18</u> 19 <u>47</u> <b>Immediate cause of death</b> <u>Carcinoma of cervix</u> <b>DURATION</b> <u>4 yrs?</u> Due to _____ Due to _____ Other conditions _____ (Include pregnancy within 3 months of death) <b>Major findings of operations</b> <u>same</u> Date of op. <u>Jan 1944</u> <b>Autopsy results</b> <u>none</u> <b>PHYSICIAN:</b> Please underline the cause to which death should be charged statistically.			
<b>22. VIOLENCE:</b> If death was due to external causes, fill in the following: Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) (County) (State) Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____				<b>23. SIGNATURE</b> <u>Red O Hodous M.D.</u> M. D. or other <u>Edgwood Md</u> Address _____ Date signed <u>1-19-47</u>			
<b>19.</b> <u>Jan 21</u> 19 <u>47</u> <u>M.M. Moulds</u> (Date rec'd by registrar) Registrar							

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JAN 23 1947

BUREAU V S

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

1572

★ 00631

Reg. Dist. No. 181

## 1. PLACE OF DEATH:

County HarfordCity or town Aberdeen  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 mos

Hospital, institution, or street address where death occurred:

19 Swan St

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town Aberdeen Md  
(If outside city or town limits, write RURAL and give nearest town)Street No. 19 Swan St

(If rural, give LOCATION)

2.(a) If veteran, name war none

## 3. (a) FULL NAME

Catherine Ann Steier

## 3. (b) Social Security Number

none4. Sex Female5. Color or race White6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Sept. 16, 19468. AGE: Years \_\_\_\_\_ Months 4 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Harce de Grace, Md  
(Town, county, and state)10. Usual occupation none11. Industry or business none12. Name Paul F. Steier13. Birthplace Red Lion, Pa14. Maiden name Bernadette Coagman15. Birthplace Dallas Texas Pa16. Informant Mr Paul F. SteierAddress 19 Swan St, Aberdeen, Md17. Removal Removal Date thereof Jan. 22, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Dallas TownLocation Pennsylvania18. Funeral director Henry Taweng & SonsAddress Aberdeen MdJan. 22 1947 Nellie H. Riley  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 21 1947 at 7:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Oct 1 1946 to Jan 21 1947and that I last saw him alive on Jan 21 1947Immediate cause of death Mongolian SclerCongenital HeartDue to anomaly

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

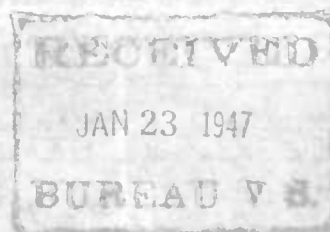
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Charles J. Foley M.D.Address Baltimore Md Date signed 1/21/47



1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00632

Reg. Dist. No. 1830

## 1. PLACE OF DEATH:

County Harford  
 City or town in Jarrettsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 23 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State md County Harford  
 City or town Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. in Jarrettsville  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Emma Florence Streett

## 3. (b) Social Security Number

4. Sex F. 5. Color or race w. 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Clarence Streett  
 6.(c) If alive, give age 80 years  
 7. Birth date of deceased (mo., day, yr.) June 21, 1866  
 8. AGE: Years 80 Months 6 Days 27 It less than one day  
 hrs. min.

9. Birthplace Balto. City  
 (Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

FATHER 12. Name Augustus J. Lettier  
 13. Birthplace Marshester Pa  
 MOTHER 14. Maiden name Elizabeth Fisher  
 15. Birthplace Brandywine, Del

16. Informant Mrs. J. Clarence Streett  
 Address Jarrettsville, Md

17. Burial Date thereof Jan. 20, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Jarrettsville  
Jarrettsville, Md.  
 Location

18. Funeral director Martin G. Kurtz  
 Address Jarrettsville, Md.

19. Jan. 20 1947 Thomas R. Brown  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 18 1947 at 2:05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 5 1944 to Jan 18 1947

and that I last saw her alive on Jan 18 1947

Immediate cause of death Coronary Thrombosis DURATION 36 hrs.

Due to

Due to

Other conditions Chr. Myocardial Disease Sx.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Willard P. Hudson M. D. or other

Address Forest Hill, Md Date signed 1/19/47



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JAN 23 1947

BUREAU V S.

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00633

Reg. Dist. No. 1820

## 1. PLACE OF DEATH:

County.....Harford  
 City or town.....Rural Aberdeen Bel Air  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....3 yrs  
 Hospital, institution, or street address where death occurred:  
 Harford Co. Home  
 How long in hospital or institution?.....3 yrs

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State.....Maryland County.....Harford  
 City or town.....Rural Aberdeen  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....Rural Chapel Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....None

## 3. (a) FULL NAME

John Mitchell Strong

## 3. (b) Social Security Number

None

4. Sex.....Male  
 5. Color of race.....White  
 6.(a) Single, married, widowed, or divorced.....Single  
 6.(b) Name of husband or wife.....  
 6.(c) If alive, give age.....years  
 7. Birth date of deceased (mo., day, yr.).....April 4 - 1867  
 8. AGE: Years.....79 Months.....9 Days.....hrs.....min.

9. Birthplace.....Harford Co. Md.  
 (Town, county, and state)  
 10. Usual occupation.....Day Laborer  
 11. Industry or business.....

12. Name.....Thomas A. Strong  
 13. Birthplace.....Harford Co. Md.  
 14. Maiden name.....Isabella Belbert  
 15. Birthplace.....Harford Co. Md.

16. Informant.....Mrs. G. Elizabeth Strong  
 Address.....Aberdeen Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?).....Date thereof.....Jan. 10 - 1947  
 (month) (day) (year)  
 Cemetery or crematory.....Wesleyan Chapel  
 Location.....Near Aberdeen Md.

18. Funeral director.....Henry Tanning Sons  
 Address.....Aberdeen Md.

19. 1/9 47 Pincilla Towood  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....JAN. 7, 1947, at.....M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 JAN. 4, 1947, to JAN. 7, 1947  
 and that I last saw him alive on JAN. 4, 1947  
 Immediate cause of death.....BRONCHO - PNEUMONIA

DURATION  
 3 DAYS  
 Due to.....FRACTURE, RT. FEMORAL NECK  
 Due to.....Accidental fall. Cause of.....  
 Other conditions.....  
 (Include pregnancy within 8 months of death)

Major findings of operations.....  
 Date of op.....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide.....Accident.....Date of January 7th, 1947  
 Where did injury occur?.....Fallston.....Harford.....Maryland  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....County.....Harford  
 Means of Injury.....Accidental fall.....Injured at work?

23. SIGNATURE.....Robert Q. Barthel MD  
 Address.....Forest Hill MD  
 Date signed.....1/9/47

RECEIVED

JAN 11 1947

BUREAU V 8

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00634

Reg. Dist. No. 1850

## 1. PLACE OF DEATH

County Harford  
 City or town Harford  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 yr.  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Harford  
 City or town Harford  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 337 Wilson  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Horace Q. Swanner

## 3. (b) Social Security Number

216-10-8093

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife Grace G. Swanner6. (c) If alive, give age 62 years7. Birth date of deceased (mo., day, yr.) Feb. 11 - 1891

8. AGE: Years 55 Months 11 Days 17 If less than one day  
 hrs. min.

9. Birthplace Maryetta Pa.  
(Town, county, and state)10. Usual occupation Fireman

11. Industry or business

12. Name Charles G. Swanner13. Birthplace Pa.14. Maiden name Elizabeth Meister15. Birthplace Pa.16. Informant Grace G. Swanner (wife)Address 337 Wilson, Harford, Pa.17. Burial Date thereof 1/31/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Balto. Nat.Location Baltimore, Md.18. Funeral director Wm. Cook Inc.Address H. Paul & P. Smith, Balto. Md.19. Jan. 28 19 47 G. D. Lewis, Jr.  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1-28- 19 47 at 4:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
1-25-47 19 47 to 1-28 19 47  
 and that I last saw him is alive on 1-27-47 19 47

Immediate cause of death auto myocarditisDue to accidentDue to cardiac decompensation

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. D. Lewis, Jr. M. D. or otherAddress Harford, Pa. Date signed 1-28-47

RECEIVED

JAN 30 1947

BUREAU V B

1-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00635 P

Reg. Diat. No. 1850

### 1. PLACE OF DEATH:

County Harford  
City or town Harford  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 4 hours  
Hospital, institution, or street address where death occurred:  
Harford Memorial Hospital  
How long in hospital or institution? 4 hrs

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD County Harford  
City or town Brackshaw  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

### 3.(a) FULL NAME

Patricia Anne Szukieritz

### 3.(b) Social Security Number

4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced Newborn  
6.(b) Name of husband or wife \_\_\_\_\_  
7. Birth date of deceased (mo., day, yr.) 1/15/47  
8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days 15 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Harford Co., Harford, Md  
(Town, county, and state)

10. Usual occupation Newborn

11. Industry or business Newborn

12. Name Joseph J. Szukieritz

13. Birthplace MD

14. Maiden name Cecilia Marie Petty

15. Birthplace MD

18. Informant Mr. Joseph J. Szukieritz

Address Brackshaw, Md

17. (Burial, cremation, or removal) Burial Date thereof 1-18-47  
(month) (day) (year)

Cemetery or crematory St. Stephens

Location Brackshaw, Md

18. Funeral director John J. Strehlau

Address 423 S. Park St.

19. Jan 17 19 47 A. W. Hedrick Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 1/15 19 47 at 11:58 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/15 19 47, to 1/15 19 47

and that I last saw her alive on 1/15 19 47

Immediate cause of death \_\_\_\_\_ DURATION 4 hr

Respiratory failure

Due to Waterhouse-Friedrichsen Syndrome

Due to Menigeo Cereemia

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Dudley Rhine M. D. or other \_\_\_\_\_

Address Harford Memorial Date signed 1/16/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00636

Reg. Dist. No. 1810

## 1. PLACE OF DEATH:

County Hartford  
City or town Aberdeen  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs.  
Hospital, institution, or street address where death occurred:  
12 Church Green

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Hartford

City or town Aberdeen, Md.  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 12 Church Green  
(If rural, give LOCATION)

2.(a) If veteran, name war None

## 3. (a) FULL NAME

Mary L. Thompson

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Samuel E. Thompson

7. Birth date of deceased (mo., day, yr.) March 10, 1894  
5. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 52 Months 10 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Jopla, Maryland  
(Town, county, and state)

10. Usual occupation Postmaster11. Industry or business U.S. Government - Retired12. Name Unknown13. Birthplace Unknown14. Maiden name Mary L. Stinchcomb15. Birthplace Hartford Co., Md.16. Informant Mr. Edward A. ThompsonAddress 12 Church Green, Aberdeen, Md.17. Burial Date thereof Jan. 29, 1947

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory GroveLocation Aberdeen, Md.18. Funeral director Henry Tarrington & SonsAddress Aberdeen, Md.19. Jan. 29, 1947 Nellie H. Wiley

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 26, 1947 at 1:00 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 2, 1945 to Jan 26, 1947and that I last saw him alive on Jan 26, 1947Immediate cause of death Coronary infarction

## DURATION

Due to Hypertensive cardiacvascular disease

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE G. B. Jastrow M.D.Address Aberdeen, Md. Date signed 1/28/47

223-91

RECEIVED

JAN 30 1947

BUREAU

1-35

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00637

Reg. Dist. No. 1810

### 1. PLACE OF DEATH:

County Harford  
City or town Rural Aberdeen  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 20 yrs  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Harford  
City or town Rural Aberdeen Md  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. R. 2nd Ave E  
(If rural, give LOCATION)  
2.(a) If veteran, name war none

### 3. (a) FULL NAME

Mary Elizabeth Tildon

### 3. (b) Social Security Number

none

4. Sex Female 5. Color or race Colored 6. ( ) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Frank Tildon Jr

6.(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) Feb. 22-1875

8. AGE: Years 71 Months 11 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore Md  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business None

12. Name Unknown

13. Birthplace Unknown

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Frank Tildon Jr

Address Aberdeen Md

17. Burial Date thereof Jan. 20-1947  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Cabury

Location Churchville Harford Co Md

18. Funeral director Benny Tanning Sons

Address Aberdeen Md

19. Jan 20 - 19 47 Nellie H. Riley  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 17<sup>th</sup> 19 47 at 11:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 January 19 47, to 17 Jan 19 47

and that I last saw him alive on 15 January 19 47

Immediate cause of death Congestive Myocardial Failure

Due to Arteriosclerotic Cardio Vascular Disease

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. M. T. Muse M.D.

Address 200 N. Union Ave. Hardec House M. D. or other \_\_\_\_\_

Date signed 1/18/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 22 1947

BUREAU V. G.

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00638

Reg. Dist. No. 1806

## 1. PLACE OF DEATH:

County Harford  
 City or town Belcamp  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State va County Grayson  
 City or town Independence  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.

## 3. (a) FULL NAME

Mary Cornelis Troy

## 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife Marcus L. Troy  
 7. Birth date of deceased (mo., day, yr.) Dec 22 1862 B.(c) If alive, give age. years  
 8. AGE: Years 84 Months 1 Days 6 If less than one day hrs. min.

9. Birthplace Virginia  
 (Town, county, and state)

10. Usual occupation Housewife

## 11. Industry or business

FATHER 12. Name William Bedwell  
 13. Birthplace Virginia  
 MOTHER 14. Maiden name Sarah Hicks  
 15. Birthplace Virginia

16. Informant Mrs Nellie Wright  
 Address Belcamp Maryland

17. Transportation Jan 28 1947  
 (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)  
 Cemetery or crematory Vaughn - Grayson Funeral Home  
 Location Salas Virginia

18. Funeral director Howard W. McCrone  
 Address Chesapeake Maryland

19. Jan 28 1947 Maria M. Moulden  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 28 1947 at 12:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6 1946 to Jan 28 1947  
 and that I last saw him alive on Jan 28 1947

Immediate cause of death coronary occlusion 3 days DURATION

Due to arteriosclerosis with hypertension Years?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Red O Hodons MD  
 M. D. or other

Address Edgewood MD Date signed 1-28-47

RECEIVED

JAN 31 1967

BUREAU

1-35



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

00639

1821

93d

Reg. Dist. No. 184

## 1. PLACE OF DEATH:

County Harford  
 City or town Whiteford  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 12 yrs  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Harford  
 City or town Whiteford  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

William J. Wallace

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Lucie S. Wallace  
 6. (c) If alive, give age 68 years  
 7. Birth date of deceased (mo., day, yr.) Jan. 28 - 1869  
 8. AGE: Years 77 Months 11 Days 27 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Harford Co. Md.  
 (Town, county, and state)

10. Usual occupation Retired farmer

11. Industry or business \_\_\_\_\_

12. Name William Wallace

13. Birthplace Harford Co. Md.

14. Maiden name Lucie Howell

15. Birthplace Harford Co. Md.

16. Informant Mrs. Lucie Wallace

Address Whiteford, Md.

17. Burial Date thereof Jan. 27 - 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or Delta Ridge cemetery

Location Delta, Pa.

18. Funeral director Robert P. Harbison

Address Delta, Pa.

19. Jan. 27, 1947 M. W. Kirk  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH January 25, 1947 at 9:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 25, 1947 to Jan. 25, 1947

and that I last saw him alive on January 24, 1947

Immediate cause of death Branchiopneumonia

Due to Cerebral Hemorrhage

and Hypertensive

Due to C-V Disease

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Jonah H. Hunt

M. D. or other \_\_\_\_\_

Address Delta, Penna Date signed 1/25/47

10000

STATE OF VERMONT DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

DECEASED: (NAME) (LAST) (FIRST) (MIDDLE)

DATE OF DEATH

PLACE OF DEATH

RECEIVED  
FEB 6 1947  
FEB 10

2-25

2-1820-2-10

NOTED: RETURNED FOR INDEXING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 18020

## 1. PLACE OF DEATH:

County HartfordCity or town Belt Air, Md  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County HartfordCity or town Belt Air Pk. Hartford Co  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Robert Wilson

## 3. (b) Social Security Number

## 4. Sex

M

## 5. Color or race

Col

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Francis Wilson6. (c) If alive, give age ✓ years

## 7. Birth date of

deceased (mo., day, yr.)

Feb 15 - 1884

## 8. AGE:

Years

Months

Days

If less than one day

62

.....hrs. ....min.

## 9. Birthplace

Baltimore Co

(Town, county, and state)

## 10. Usual occupation

Farm labor

## 11. Industry or business

FATHER

## 12. Name

Quill Wilson

## 13. Birthplace

Md

MOTHER

## 14. Maiden name

Sarah E Jones

## 15. Birthplace

Pa

## 16. Informant

Wm Wilson

## Address

Rocks, Md

## 17. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

Jan 5 / 47  
(month) (day) (year)

## Cemetery or crematory

Fawn Grove

## Location

Fawn Grove Pa

## 18. Funeral director

Dean & Intd

## Address

Belt Air Md

## 19. 1/3

(Date rec'd by registrar)

47 Privella Toward

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

Jan 219 47

at

5:30 A.M

## 21. I CERTIFY that death occurred on the date above stated; (was) attended deceased from

Dec 3119 46

to

Jan 219 47and that I last saw him alive on Dec 31 19 46

## Immediate cause of death

Chronic myocarditis

## DURATION

unknown

## Due to

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

A. F. Van Bibber M.D.

Address

Belt Air, Md.

Date

Jan 3 / 1947

RECEIVED

JAN 4 1947

BUREAU P. S.

1-35-